MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05241 — 05237

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Berlin
c. LENGTH OF STAY IN 1b: 2 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Berlin Nursing Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
d. STREET ADDRESS: 22 x 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Eva — Middle: Mae — Last: Cooper

4. DATE OF DEATH: Month: April — Day: 25 — Year: 1962

5. SEX: White

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: May 10, 1877

9. AGE (In years last birthday): 84 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Mitchell Davis

14. MOTHER'S MAIDEN NAME: Roena Dennis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service)

16. SOCIAL SECURITY NO.: 217-36-1482D

17. INFORMANT — Address: Harry Cooper — Frankford, Del RFD

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocarditis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis - Hypertension
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus. 15 years.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. I certify that (I) (this hospital) attended the deceased from 1940, 19..., to day of death, that (I) (we) last saw the deceased alive on 4-25 1962 and that death occured at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Frank Lewis M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Willards Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/29/62

23c. NAME OF CEMETERY OR CREMATORY: Cooper Family

23d. LOCATION (City, town or county) (State): Willards Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley — ADDRESS: Selbyville Del

25a. REC'D BY REGISTRAR — DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Edward E. Hurst

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05242

CERTIFICATE OF DEATH

05238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

X

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b: 76 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS
a. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Viola — Middle: M. — Last: Griffin

4. DATE OF DEATH: Month: April — Day: 15 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Dec 7 1886

9. AGE (In years last birthday): 75/4/11 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Snow Hill Md

12. CITIZEN OF WHAT COUNTRY?

I

13. FATHER'S NAME: Jesse W. Messick

14. MOTHER'S MAIDEN NAME: Harriett Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr Horace L Griffin, Snow Hill Md — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours
DUE TO (b): Essential Hypertension — Years
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-6, 19 62 to 4-17, 1962, that (I) (we) last saw the deceased alive on 4-17 19 62, and that death occured at 7 AM, from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 4-18-62

22c. PHYSICIAN'S NAME (Type): David Rafat, M. D.

22d. ADDRESS: 104 Bay St., Snow Hill, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: April 20 62

23c. NAME OF CEMETERY OR CREMATORY: Whatcoat Cemetery

23d. LOCATION (City, town or county) (State): Snow Hill Md

24 FUNERAL DIRECTOR'S SIGNATURE: Ellaye Dennis — ADDRESS: Snow Hill, Md

25a. REC'D BY REGISTRAR DATE: APR 19 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05243 / 05239

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
c. LENGTH OF STAY IN 1b: 84 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Md
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill
d. STREET ADDRESS: 306 W. Martin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Ernest — Last: Martin

4. DATE OF DEATH: Month: April — Day: 6 — Year: 1962

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: July 13 1877
9. AGE (In years last birthday): 84 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labour
10b. KIND OF BUSINESS OR INDUSTRY: Outlying Factory
11. BIRTHPLACE (County & State, or foreign country): Snow Hill Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Alexander Martin
14. MOTHER'S MAIDEN NAME: Unknown
330 E 11th St

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 242-10-7648A
17. INFORMANT (Name, address): Mrs Maylo J. Dillitt, Chester, Pa.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: few hours
DUE TO (b): ASHD — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

420.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-6, 1962 to 4-6, 1962, that (I) (we) last saw the deceased alive on 4-6 1962 and that death occured at 1.0 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 4-9-62
22c. PHYSICIAN'S NAME (Type): DAVID RAFAT
22d. ADDRESS: Snow Hill Md

23a. BURIAL, CREMATION, REMOVAL (Specify)
23b. DATE THEREOF: April 9/62
23c. NAME OF CEMETERY OR CREMATORY: Pitts Memorial Cemetery
23d. LOCATION (City, town or county) (State): Snow Hill Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Elmer E. Timmins, Snow Hill, Md

25a. REC'D BY REGISTRAR DATE: APR 11 '62
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

- 1

FOR STATE HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05244

05240

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton
c. LENGTH OF STAY IN 1b: 83 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Stockton
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Elmer; Middle: P.; Last: Parsons

4. DATE OF DEATH: Month: April; Day: 17; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Oct. 28, 1878

9. AGE (In years last birthday): 83/5/17

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Local

11. BIRTHPLACE (State or foreign country): Stockton, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Jehu Parsons

14. MOTHER'S MAIDEN NAME: Mary E. Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Miss Maude E. Parsons, Stockton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot Wound in the Abdomen
9767
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental depression

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: J. Ruddle Lamar M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 4-18-62

EXAMINER'S NAME (Type): Robert C. La Mar, M.D., 104 Bay St., Snow Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 20/62

22c. NAME OF CEMETERY OR CREMATORY: Portersville Cemetery

22d. LOCATION (City, town, or county) (State): Stockton Md.

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Norman F. Dennis, Snow Hill, Md.

24a. REC'D BY REGISTRAR — DATE: APR 20 '62

24b. REGISTRAR'S SIGNATURE

Courtney L. Truitt

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any ... is necessary, please ... certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the ... director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

105245 105241

1. PLACE OF DEATH
a. COUNTY Worcester MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
c. LENGTH OF STAY IN 1b 88 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
d. STREET ADDRESS 216 E. Martin
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Thomas Middle E Last Richardson
4. DATE OF DEATH Month April Day 30 Year 1962
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Dec. 6 1873
9. AGE (In years last birthday) 88/4/24
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant
10b. KIND OF BUSINESS OR INDUSTRY Chain Store
11. BIRTHPLACE (County & State, or foreign country) Snow Hill Md
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Thomas H. Richardson
14. MOTHER'S MAIDEN NAME Margaret Bowen
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT Address Mrs Margaret H. Richardson Snow Hill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) ARTERIO SCLEROSIS
DUE TO (c)
420.1
INTERVAL BETWEEN ONSET AND DEATH MINUTES 15 YRS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) NON FATAL CORONARY OCCLUSION 1956
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from June, 1958 to Apr. 30, 1962, that (I) (~~we~~) last saw the deceased alive on April 26 1962 and that death occured at 3:30 AM from the causes and on the date stated above.

22a. SIGNATURE Robert C. Lamar M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 4/30/62
22c. PHYSICIAN'S NAME (Type) Robert C. LAMAR
22d. ADDRESS 104 BAY ST. SNOW HILL, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial May 2/62
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY Whitecoat Cemetery
23d. LOCATION (City, town or county) Snow Hill (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE Elbert E. Timms
ADDRESS Snow Hill, Md
25a. REC'D BY REGISTRAR DATE MAY 3 '62
25b. REGISTRAR'S SIGNATURE Orlan S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05246 — 05242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH — a. COUNTY: Worcester — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree — c. LENGTH OF STAY IN 1b: 72yrs — d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, residence before admission) — a. STATE: Md — b. COUNTY: Worcester — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree — d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Martin — Last: Riley

4. DATE OF DEATH: Month: April — Day: 8 — Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan 31 1890

9. AGE (In years last birthday): 72 yrs — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (County & State or foreign country): Girdletree Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James Riley

14. MOTHER'S MAIDEN NAME: Mary Stanford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — If so, give war or dates of service

16. SOCIAL SECURITY NO. 219-14-3538

17. INFORMANT — Address: Mrs Annie A. Riley, Girdletree Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): ASHD

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-8, 1962 to 4-8, 1962 that (I) (we) last saw the deceased alive on 4-8-1962, and that death occured at 3 P.M. from the causes and on the date stated above.

22a. SIGNATURE: David Rafat M.D.

22b. DATE SIGNED: 4-9-62

22c. PHYSICIAN'S NAME (Type): DAVID RAFAT

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Snow Hill, Md.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: April 11/62 — 23c. NAME OF CEMETERY OR CREMATORY: Springfield Cemetery — 23d. LOCATION (City, town or county): Girdletree — (State) Md

24. FUNERAL DIRECTOR'S SIGNATURE: Tilley & Timmis — ADDRESS: Snow Hill, Md

25a. REC'D BY REGISTRAR — DATE: APR 11 '62 — 25b. REGISTRAR'S SIGNATURE: Arthur L. Timmis

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05247

CERTIFICATE OF DEATH

05243

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL BERLIN
c. LENGTH OF STAY IN 1b: 71 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL BERLIN
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: MARGIE Middle: ANNA Last: TAYLOR

4. DATE OF DEATH: Month: APRIL Day: 29 Year: 1962

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 25 1890

9. AGE (In years last birthday): 71 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): WORCESTER NEWARK, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard HARMON

14. MOTHER'S MAIDEN NAME: Anna Richardson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: 221-01-4013

17. INFORMANT: Address: FARREll TAYLOR BERLIN Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Coronary occlusion acute	Instant
DUE TO	Myocardial failure severe	5 years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO (b)	AS Cardiovascular disease	5 years
DUE TO (c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diverticulitis acute

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 1960 to April 29, 62, that (I) (we) last saw the deceased alive on April 29, 1962, and that death occured at 1:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature]

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ M.D.

22b. DATE SIGNED: April 29, 62

22c. PHYSICIAN'S NAME (Type): THOMAS J TOWNSEND JR

22d. ADDRESS: Ocean City, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 1, 1962

23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN

23d. LOCATION (City, town or county): BERLIN (State): MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: Anna A. Burbage

ADDRESS: Berlin, Md.

25a. REC'D BY REGISTRAR DATE: MAY 3 '62

25b. REGISTRAR'S SIGNATURE: Arthur S. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05248 — 05244

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with n 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. PLACE OF DEATH
a. COUNTY: Worcester
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop
c. LENGTH OF STAY IN 1b: 32 Yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): EX

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Bishop
d. STREET ADDRESS: 1 RFD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Dewey; Middle: Franklin; Last: Tingle

4. DATE OF DEATH: Month: April; Day: 27; Year: 1962

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 24, 1898

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George P. Tingle

14. MOTHER'S MAIDEN NAME: Anna M. Campbell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mrs. Gal Cropper Bishop, Md. (Address)

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): 4-22 — Acute Myocarditis,
DUE TO (b): Chronic Myocarditis
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 4-26 19 62 to 4-27 19 62 that (I) (we) last saw the deceased alive on 4-26 19 27, and that death occured at 2:17 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): CLIFFORD E. SCHOTT MD

22d. ADDRESS: BERLIN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 4/29/62

23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows

23d. LOCATION (City, town or county): Bishopville, Md. (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Peter Whaley

ADDRESS: Selbyville Del.

25a. REC'D BY REGISTRAR DATE: APR 30 '62

25b. REGISTRAR'S SIGNATURE: Acting L. Krause

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05248 Item 1 Film 6512 5/16/62 jwk 05245

1. PLACE OF DEATH
a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): on scene of death-

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: WOR
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): R 2 Berlin
d. STREET ADDRESS: R 2 Berlin
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First FRANKLIN Middle WILLIAM Last Tubbs

4. DATE OF DEATH: Month APRIL Day 26 Year 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 8, 1910

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WATERMAN

10b. KIND OF BUSINESS OR INDUSTRY: Sea Food

11. BIRTHPLACE (State or foreign country): Bishopville Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Tubbs

14. MOTHER'S MAIDEN NAME: Minnie Savage

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-10-4266

17. INFORMANT: Mrs Myrtle Tubbs (Wife) Address: R2 Berlin, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4
DUE TO (b): 1
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(a) Coronary Occlusion Acute — INTERVAL BETWEEN ONSET AND DEATH: 1 hour
(b) A.S. Coronary artery disease — 4 years.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [ ], and in my opinion death resulted from. Natural causes [X] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [ ]

ACTUAL SIGNATURE: F J Townsend Jr M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

EXAMINER'S NAME (Type): Francis J & Townsend JR

Address (Street, City, town, or county): Ocean City, Md

DATE SIGNED: April 26, 62.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: April 29, 1962

22c. NAME OF CEMETERY OR CREMATORY: St. Martins

22d. LOCATION (City, town, or country) (State): Bishopville Maryland

23. FUNERAL DIRECTOR: Owen A. Burbage ADDRESS: Berlin Md

24a. REC'D BY REGISTRAR DATE: MAY 1 '62

24b. REGISTRAR'S SIGNATURE: Arthur E. Fraser

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05252

CERTIFICATE OF DEATH

Reg. Dist. No. 05218

1. PLACE OF DEATH
a. COUNTY Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishop
c. LENGTH OF STAY IN 1b: ?
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville
d. STREET ADDRESS Rural Box 273
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Alice — Middle — Last Wooden
4. DATE OF DEATH: Month Apr. — Day 21 — Year 1962
5. SEX: Female
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 10, 1901
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Portsmouth, Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Rhubin Jackson
14. MOTHER'S MAIDEN NAME: Julia Hunt
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Augustus Wooden — Address: Bishop, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 wks
DUE TO (b) Hypertensive C-V Disease — 8 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3/14, 1957 to 4/19, 1962, that I last saw the deceased alive on 4-19, 1962, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Ivory U. Sully Jr. M.D. ADDRESS (Street, city or town, state) Berlin Md DATE SIGNED 4/24/62

PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr. M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 4/28/62
22c. NAME OF CEMETERY OR CREMATORY: Lincoln
22d. LOCATION (City, town, or county) (State): Portsmouth Va.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry W. Watson ADDRESS: Pocomoke City, Md.
24a. REC'D BY REGISTRAR DATE APR 26 '62
24b. REGISTRAR'S SIGNATURE: Charles L. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 4 ... retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

05250

CERTIFICATE OF DEATH

05246

1. PLACE OF DEATH
a. COUNTY: WORCESTER — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL NEWARK
c. LENGTH OF STAY IN 1b: 61 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X RURAL NEWARK Md.
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: Thomas — Last: WARREN JR.

4. DATE OF DEATH: Month: April — Day: 27 — Year: 1962

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 9, 1901

9. AGE (In years last birthday): 61 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): IRONSHIRE Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William WARREN

14. MOTHER'S MAIDEN NAME: JENNIE GAULT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-30-8038

17. INFORMANT — Address: Nelda Lee WARREN NEWARK,

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Operation cervical gland
DUE TO (c): 4201

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 4-1-62, 19 62 to 4-27, 19 62, that (I) ~~(we)~~ last saw the deceased alive on 4-27 19 62, and that death occured at 7 3c M, from the causes and on the date stated above.

22a. SIGNATURE: Clifford E. Schott M.D.

ATTENDING PHYS. X — MED. DIRECTOR ☐ — STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): CLIFFORD E. SCHOTT MD

22d. ADDRESS: BERLIN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: April 29, 1962

23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL

23d. LOCATION (City, town or county) (State): BERLIN MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Anna A. Burbage Berlin, Md.

25a. REC'D BY REGISTRAR DATE: MAY 1 '62

25b. REGISTRAR'S SIGNATURE: Arthur L. Kuna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05251 05247

1. PLACE OF DEATH — a. COUNTY: Worcester — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and nearest town): Girdletree
c. LENGTH OF STAY IN 1b: 62 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) — a. STATE: Md — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Girdletree
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Carrie — Middle: D. — Last: Webb

4. DATE OF DEATH: Month: April — Day: 10 — Year: 1962

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 27-1888

9. AGE (In years last birthday): 73/9/13

IF UNDER 1 YEAR — Months: — Days:
IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Salisbury, Md

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William E. Dickerson

14. MOTHER'S MAIDEN NAME: Arra Jane Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wars or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Mr Harold W. Webb Girdletree Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Breast — INTERVAL BETWEEN ONSET AND DEATH: 3 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Metastatic Cancer to Lung
DUE TO (c): Omentum — 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

2Dc. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐

2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

2Df. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1958, 19..... to April 10, 19 62 that (I) (we) last saw the deceased alive on April 9 19 62 and that death occured at M, from the causes and on the date stated above.

22a. SIGNATURE: Paul Cohen M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial April 13

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

23d. LOCATION (City, town or county) (State): Girdletree, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Elloy E. Timms

ADDRESS: Snow Hill Md

25a. REC'D BY REGISTRAR DATE: APR 13 '62

25b. REGISTRAR'S SIGNATURE: Clifton S. Horne

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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